AND PLAN OF CORRECTION 155780 155780	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPL	(X3) DATE SURVEY	
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) This visit was for a Recertification and State Licensure Survey. Survey dates: August 27, 28, 29, 30, 31, 2012. Facility number: 012225 Provider number: 155780 AIM number: 200983560 Survey Team: Courtney Mujic, RN- TC Karina Gates, Medical Surveyor Beth Walsh, RN Census Bed Type: SNF: 12 CX4) ID PREFIX (A40) ID PRECIDENCE (IDENTIFYING INFORMATION) This plan of correction is to serve as Madison Health Care Centers' credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Madison Health Care Center or its' management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of numbising care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations. We are in full compliance as of 09/30/2012 and respectfully REQUESTPAPER	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
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Beth Walsh, RN Census Bed Type: SNF: 12 SNE/NE: 40 admission of the survey allegations. We are in full compliance as of 09/30/2012 and respectfully REQUESTPAPER		Karina Gates,	Medical Surveyor			
Census Bed Type: SNF: 12 CNE(NF: 48) compliance as of 09/30/2012 and respectfully REQUESTPAPER		Beth Walsh, F	RN		_	
SNF: 12 CNE/NE: 40 CNE/NE: 40					allegations. We are in full	
SNF: 12 and respectfully REQUESTPAPER		Census Bed T	ype:		compliance as of 09/30/2012	•
CNIC/NIC: 40						
LONGAN TO LOOMBLANCE		SNF/NF: 48			respectfully REQUESTPAPE COMPLIANCE.	:R
Total: 60					COMPLIANCE.	
Census Payor Type:		Census Pavor	· Tyne·			
Medicare: 10		_	. , , , ,			
Medicaid: 34						
Total: 60		10tal: 60				
Those deficiencies reflect Ctate		Thomas deficien	aning radioat Ctata			
These deficiencies reflect State						
findings cited in accordance with 410			in accordance with 410			
IAC 16.2.		IAC 16.2.				
Quality review completed on			•			
September 9, 2012 by Bev Faulkner,		•	2012 by Bev Faulkner,			
RN		RN				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

012225

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CO A. BUILDING B. WING	00	08/31	LETED /2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP C ADISON AVE	ODE	
	N HEALTH CARE C	CENTER		APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ11

Facility ID: 012225

If continuation sheet Page 2 of 25

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155780	B. WIN			08/31/	2012
			_		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P.	ROVIDER OR SUPPLIER	C		7465 M	ADISON AVE		
	N HEALTH CARE (CENTER		<u> </u>	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
				TAG	DEFICIENCY)		DATE
F0156 SS=A	483.10(b)(5) - (10) NOTICE OF RIGICHARGES The facility must is orally and in writing resident understate all rules and regulation conduct and respin the facility. The the resident with state developed that Act. Such notification or upon admissionstay. Receipt of amendments to its writing. The facility must is entitled to Medicate the time of admissions, when the resident must included in nursing State plan and for not be charged; the resident may amount of charges inform each resident may amo	inform the resident both and in a language that the ands of his or her rights and allations governing resident both and in a language that the ands of his or her rights and allations governing resident bonsibilities during the stay are facility must also provide the notice (if any) of the and during the resident's such information, and any are the and during the resident's such information, and any are the area of a color of the area		TAG	DEFICIENCY)		DATE
	The facility must to of legal rights whi	furnish a written description ich includes:					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ11

Facility ID: 012225

If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155780	B. WING			08/31/	2012
			D. WINC		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ADISON AVE		
MADISO	N HEALTH CARE	CENTER			APOLIS, IN 46227		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
		the manner of protecting under paragraph (c) of this					
	procedures for e Medicaid, includ assessment und determines the e non-exempt resc institutionalization community spouresources which available for pay institutionalized or her process of Medicaid eligibil						
	telephone numb client advocacy survey and certilicensure office, program, the pronetwork, and the and a statement complaint with the certification age abuse, neglect, resident property non-compliance requirements. The facility must requirements spurite policies and advance directive include provision written informatic concerning the resulting surveys and the survey and the survey and the surveys and the surve	nes, addresses, and ers of all pertinent State groups such as the State fication agency, the State the State ombudsman etection and advocacy Medicaid fraud control unit; that the resident may file a ne State survey and ncy concerning resident and misappropriation of y in the facility, and with the advance directives comply with the ecified in subpart I of part ter related to maintaining and procedures regarding es. These requirements as to inform and provide on to all adult residents ight to accept or refuse cal treatment and, at the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 35SZ11

Facility ID: 012225

If continuation sheet Page 4 of 25

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155780	B. WIN			08/31/	2012
NAME OF I	PROVIDER OR SUPPLIEI			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIED	X			ADISON AVE		
	N HEALTH CARE (APOLIS, IN 46227		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG		n, formulate an advance	+	TAG	,		DATE
		cludes a written description					
		plicies to implement					
		es and applicable State law.					
	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.						
	P.170.0.0111100p011						
		prominently display in the					
		ormation, and provide to					
		plicants for admission oral					
		nation about how to apply					
	for and use Medicare and Medicaid benefits, and how to receive refunds for previous						
		ed by such benefits.					
	Based on inter	view and record	F01	56	F156 483.10(b)(5)-(10), 483.1	0(b)	09/30/2012
	review, the fac	ility failed to ensure			(1) NOTICE OF RIGHTS,		
	Medicare bene	eficiary residents were			RULES, SERVICES, CHARGESIt is the practice of Madison Health Care Center to provide Medicare beneficiary residents appeal notices timely including the potential liability amount for the		
	issued appeal	notices timely and					
	notified of the	potential liability					
	amount for nor	n-covered stay in the					
	facility. This a	ffected 2 of 3 Medicare					
	beneficiaries w	ho were reviewed for			non-covered stay.l. Resident #113 and #73 no longer reside	a in	
	appropriate lia	bility and appeal			the facility.II. The facility realiz		
	notices. (Resi	dents #113 and #73)			other residents on Medicare h		
					the potential to be affected.III.		
	Findings include	de:			The Social Services Director a	ınd	
					the Business Office Manager have been re-educated on the		
	1	d appeal notices for			provision of the non-covered		
		3 and #73 were			letter to include the potential		
	reviewed on 8/	/30/12 at 11:30 a.m.			liability amount on the notificat	tion	
					and to provide the notification		
		Resident #113			within 48 hours. This will be monitored through our quality		
	· ·	e Effective Date			improvement program as		
	Coverage of Y	our Current Skilled			indicated below. IV. The		
	Nursing Service	es Will End: 3/29/12."			Administrator or her designee	will	
	The notice incl	uded the signature of			review all non-covered appeal		

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			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155780	B. WIN			08/31/	2012
NAME OF B	DOMDED OD GUDDI IEI		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIEF	X.		7465 M	ADISON AVE		
MADISO	N HEALTH CARE (CENTER		INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
		, dated 3/29/12. No			notices to ensure the notice wa		
	•	t was included in the			provided timely and includes the potential liability amount.	ie	
	notice.						
	The notice for	Resident #73 indicated,					
	"The effective	date coverage of your					
	current skilled	nursing services will					
	end: 4/6/12,"	The notice included the					
	signature of Re	esident #73 dated					
	4/5/12. No liab	oility amount was					
	included in the	•					
	An interview w	as conducted with the					
	Social Services	s Director on 8/30/12 at					
		indicated she did not					
	know about the						
		the time the above 2					
	-	ssued or about putting a					
		t on the notice. She					
	_						
		was having them sign					
	the notice on ti	heir way out the door.					
	0.4.4(5)(0)						
	3.1-4(f)(3)						
			1				

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Event ID: 35SZ11

Facility ID: 012225

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DBIG	00	COMPL	ETED
		155780	A. BUII B. WIN			08/31/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADISON AVE		
MADISO	N HEALTH CARE C	CENTER			APOLIS, IN 46227		
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0241 SS=D	483.15(a) DIGNITY AND RE INDIVIDUALITY The facility must pin a manner and i maintains or enhadignity and respector her individuality. Based on observed for 1 of the clinical recovered for 1	promote care for residents in an environment that ances each resident's et in full recognition of his y. Invation, interview, and the facility failed to dent's dignity by not e collection bag if 3 residents reviewed eter use (Resident e: Ord for Resident #51 on 8/30/12 at 10:30 noses for Resident #51 ere not limited to: n, benign prostatic and neurogenic bladder. ervation on 8/28/12 at ident #51's urinary as noted to be	F02		F241 483.15(a) DIGNITY It is a practice of Madison Health Ca Center to promote care for residents in a manner and in a environment that maintains or enhances each resident's dign and respect in full recognition this or her individuality. I. Resident #51's catheter bag we covered during the survey. If yesidents with indwelling catheters have the potential to affected. This is being address by the systems described belo III. Nursing personnel have be re-educated on the importance using catheter bag covers to preserve resident dignity. This being monitored through our quality improvement program. The Director of Nursing or her designee is completing a quali improvement audit of catheter bag covers. All residents will be monitored weekly for 30 days; then every other week for 30 days; then monthly thereafter the ensure the dignity bag is in pla Results of all audits are being discussed monthly at the qual assurance meeting for addition recommendations as necessar	n ity of as All be sed w. een e of s is IV ty be coe. ity nal	09/30/2012

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Event ID: 35SZ11

Facility ID: 012225

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155780	A. BUILDING B. WING	00		LETED /2012
	PROVIDER OR SUPPLIER N HEALTH CARE CENTER	STREET A	ODDRESS, CITY, STATE, ZIP COI ADISON AVE APOLIS, IN 46227	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	indicated on 8/30/12 at 2:40 p.m., all residents that have a urinary catheter should have their urine collection bag covered to enhance resident's dignity.				
	3.1-3(t)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155780	A. BUIL			08/31/	2012
			B. WIN	_	ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE		
MADICO	NILIEAL TIL CADE C	SENTED			ADISON AVE		
MADISOI	N HEALTH CARE C	ENTER		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	483.20(d), 483.20	O(k)(1)]	
SS=D	DEVELOP COMP	PREHENSIVE CARE					
	PLANS						
		e the results of the					
		evelop, review and revise					
	the resident's con	nprehensive plan of care.					
	6 W						
		develop a comprehensive					
		h resident that includes ctives and timetables to					
	-	medical, nursing, and					
		nosocial needs that are					
		omprehensive assessment.					
	The care plan mu	st describe the services					
	that are to be furr	nished to attain or maintain					
	the resident's hig	hest practicable physical,					
		hosocial well-being as					
		183.25; and any services					
		vise be required under					
	-	not provided due to the					
		e of rights under §483.10,					
		t to refuse treatment under					
	§483.10(b)(4).		EOO	70	F070 400 00(4) 400 00(1)(4)		09/30/2012
	December	mostical total and	F02	19	F279 483.20(d), 483.20(k)(1)		09/30/2012
		ervation, interview, and			COMPREHENSIVE CARE		
		the facility failed to			PLANS It is the practice of Madison Health Care Center to	_	
	ensure a reside	ent had a care plan			review and revise the resident	-	
	addressing der	ntal status for 1 of 3			comprehensive care plan. I. A		
	•	wed in a sample of 3			indicated in the survey report,	.~	
		s and services and			Resident #32 does not have he	er	
		nt had a care plan			upper dentures with her in the		
					facility. She refused the facility		
	_	ipsychotic medication			request to have her responsibl		
		residents reviewed in			party bring her dentures to the	:	
	•	for unnecessary			facility. Her care plan was		
	medication use	e. Residents #32 and			updated during the survey.		
	69.				Resident #69's care plan has		
					been updated to include the us		
	Findings includ	le·			of the psychotropic medication		
	i manga moluu	···			II. Residents with dentures an	u	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITT	DDIG	00	COMPL	ETED
		155780		LDING		08/31/	2012
			B. WIN				_
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
					ADISON AVE		
MADISO	N HEALTH CARE (CENTER		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					those who utilize psychotropic		
	1 The clinical	record for Resident			medications have the potentia	l to	
#32 was reviewed on 8/29/12 at				be affected. An oral assessme	ent		
				was completed on all residents			
	11:00 a.m.				further identify any other resid	ents	
					with missing teeth or dentures		
	The diagnoses	for Resident #32			Care plans were updated		
	_	vere not limited to:			accordingly. Residents who u		
	· · · · · · · · · · · · · · · · · · ·	geal Reflux Disease			psychotropic medications have		
	and Anemia.	godi i toliak biocase			been reviewed and the care pl	an	
	and Anemia.				has been updated where		
					necessary. III. Licensed nurse		
	During an inter	view with Resident #32			were re-educated regarding th	е	
	on 8/28/12 at 1	l1:25 a.m., she			importance of completing an		
	indicated her t	top dentures did not fit,			accurate oral assessment. A	new	
		ot wear them because			oral assessment tool was	h:a	
					implemented to further aid in t process. Licensed nurses we		
	1 .	in her mouth. She			educated on the use of this	E	
		nad problems eating in			assessment form. Licensed		
		d for her to chew			nurses and Social Service		
	certain foods.	She also indicated she			personnel were re-educated o	n	
	did not even ha	ave her top dentures			the importance of providing a		
	with her at the	•			of care for residents who recei		
	With high de this	lacinty			psychotropic medications. IV.		
	Om 0/00/40 =±	11.00 a m. Desident			The Director of Nursing or her		
		11:29 a.m., Resident			designee is completing quality		
		ved with no top			improvement audits. A randor	n	
	dentures in he	r mouth and no top			sample of 10% of resident car		
	teeth.				plans will be reviewed to ensu	re	
					that dental status and		
	No care plan o	ould be found in the			psychotropic medications are		
		I that addressed			addressed appropriately. Qua	ility	
					improvement audits will be		
	Resident #32's	above dental			completed weekly for 30 days:		
	condition.				then every other week for 30		
					days; then monthly thereafter. Results of all audits are being		
	During an inter	view with the DON			discussed monthly at the quali	tv	
		rsing) on 8/31/12 at			assurance meeting for addition		
	·	e indicated she			recommendations as necessa		
	l				Teconinendations as necessa	ıy.	
	expected there	e to be a care plan for					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MI A. BUII		NSTRUCTION 00	(X3) DATE : COMPL	
		155780	B. WIN			08/31/	2012
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE ADISON AVE		
MADISO	N HEALTH CARE (CENTER			APOLIS, IN 46227		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	(X5) COMPLETION DATE
	Resident #32 h with her as wel either nutrition	naving no top dentures I as no top teeth, by or by nursing.					2.112
		record for Resident ved on 8/30/12 at 2:00					
	included, but w	for Resident #69 rere not limited to: status and dementia disturbances.					
	with dinner. The (Medication Adindicated Rispersident #69 c	order indicated vas to receive antipsychotic 25 mg by mouth daily ne August, 2012 MAR aministration Record) erdal was given to laily from 8/2/12 and daily from 8/16/12					
	•	• •					
	8/31/12 at 1:27 "We have a bit need to make s	view with the DON on p.m., she indicated, of a disconnect. We sure behaviors and ions) go together when					

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PRINTED: 09/26/2012 FORM APPROVED OMB NO. 0938-0391

	of Correction identification number: 155780	(X2) MULTIPLE CONS A. BUILDING B. WING	00	COMPLETED 08/31/2012
	PROVIDER OR SUPPLIER N HEALTH CARE CENTER	STREET ADD 7465 MAD	DRESS, CITY, STATE, ZIP CODE DISON AVE POLIS, IN 46227	•
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	we care planSocial Services is not looking at meds at all in their care plans. We'll probably look at revamping that."			
	3.1-35(a)(1)			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTI	IPLE CON	STRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	lG	00	COMPLI	
		155780	B. WING			08/31/	2012
	PROVIDER OR SUPPLIER		74	465 MA	DDRESS, CITY, STATE, ZIP CODE DISON AVE POLIS, IN 46227		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	II	D	DROVIDERS DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PRE	EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)	_	DATE
F0280 SS=D	CARE-REVISE Of The resident has incompetent or of incapacitated und participate in plar changes in care at the A comprehensive developed within of the comprehen by an interdisciplity the attending phy with responsibility appropriate staff in by the resident's practicable, the puther esident's far representative; and revised by an after each assess Based on interreview, the factor resident's anxiet refusal of non-infor 1 of 10 resides ample of 10 for medication used. Findings including The clinical recovers and reviewed of a.m. The diagnoses	the right, unless adjudged therwise found to be a ter the laws of the State, to ming care and treatment or and treatment. The care plan must be a to discovere assessment; prepared the resident, and other and disciplines as determined the eds, and, to the extent articipation of the resident, and periodically reviewed the early and record the resident of qualified persons the eds, and the resident of qualified persons the eds and record the extent articipation of the resident of qualified persons the edge of qualified persons the edge of qualified to update a test of care plan to include the edge of	F0280		F280 483.20(d)(3), 483.10(k)(2 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CARE PLAN It is the practice Madison Health Care Center to develop a comprehensive care plan within 7 days after completion of the comprehensi assessment; prepared by an interdisciplinary team, that includes the attending physicia a registered nurse, and other appropriate staff in disciplines determined by the resident's needs, and to the extent practicable, the participation of the resident, the resident's fam or legal representative; and periodically reviewed and revis by a team of qualified persons	of o e ive an, as f nily	09/30/2012

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A BUILDING 00 COMPLETED 08/31/2012 NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) The August, 2012 MAR (medication administration record) indicated Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. A BUILDING 00 COMPLETED 08/31/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANAPOLIS, IN 46227 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG 18 AUGUST 19 AUGUST 1
NAME OF PROVIDER OR SUPPLIER MADISON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The August, 2012 MAR (medication administration record) indicated Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE INDIANA (IN 46227 INDIANAPOLIS, IN 46227 ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG The August, 2012 MAR (medication administration record) indicated Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12.
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MADISON HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG The August, 2012 MAR (medication administration record) indicated Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. (X5) PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG Additional PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY. TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY. TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY. TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY. TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY. TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY. TAG THE PROVIDERS PLAN OF CORRECTION (CACH CORRECTI
MADISON HEALTH CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG The August, 2012 MAR (medication administration record) indicated Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. ID PROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG PREVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE After each assessment. I. Resident #110's care plan has been updated to include refusal of non-drug behavior interventions. II. The facility realizes residents who receive PRN psychoactive medications have the potential to
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The August, 2012 MAR (medication administration record) indicated Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE COMPLETION DATE After each assessment. I. Resident #110's care plan has been updated to include refusal of non-drug behavior interventions. II. The facility realizes residents who receive PRN psychoactive medications have the potential to
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) The August, 2012 MAR (medication administration record) indicated Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. PREFIX TAG After each assessment. I. Resident #110's care plan has been updated to include refusal of non-drug behavior interventions. II. The facility realizes residents who receive PRN psychoactive medications have the potential to
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Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. non-drug behavior interventions. II. The facility realizes residents who receive PRN psychoactive medications have the potential to
Resident #110 was given PRN (as needed) Xanax (anxiety medication) on 8/18/12, 8/22/12, and 8/26/12. In the facility realizes residents who receive PRN psychoactive medications have the potential to
needed) Xanax (anxiety medication) who receive PRN psychoactive medications have the potential to
on 8/18/12, 8/22/12, and 8/26/12. medications have the potential to
011 01 101 12, 0122/12, 0110 0120/121
these residents have been
No information could be found in the reviewed and updated where
clinical record to indicate any necessary. III. Licensed nurses
non-medicinal interventions were and Social Service personnel
attempted prior to giving the PRN have been re-educated regarding
anxiety medication on the above the importance of care planning a
three dates. resident's refusal of non-drug behavior interventions. This is
being monitored through our
During an interview with the ADON quality improvement program. IV.
(Additional Director of Marshing) of the designed is completing quality
8/31/12 at 3:45 p.m., she indicated improvement audits. A random
there was no verification of any sample of 10% of resident
interventions attempted prior to records are being audited to
administering the PRN anxiety ensure that non-drug
medication on the above three dates.
She indicated Resident #110 refused to utilizing PRN psychotropic
any other interventions prior to medications; and that any refusal of non-drug methods are
administering her PRN anxiety documented as part of the
medication because the medication resident's plan of care. These
was "all she wants." audits are being completed
was all she wants. weekly for 30 days; then every
other week for 30 days; then
Review of the 8/24/12 anxiety care monthly thereafter. Results of all
plan for Resident #110 did not audits are being discussed
address her refusal of non-medicinal monthly at the quality assurance
interventions. meeting for additional recommendations as necessary.
During an interview with the Social
Services Director on 8/31/12 at 3:48
p.m., she indicated she was unaware

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/26/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155780	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMI	E SURVEY PLETED 1/2012
	ROVIDER OR SUPPLIER		7465 M	ADDRESS, CITY, STATE, ZIP ADISON AVE APOLIS, IN 46227	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	did not include plan. She state	interventions so she it in the anxiety care ed, "No one told me sing non-medicinal efore today."				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780			(X2) MULTIPLE (A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED
		155780	B. WING		08/31/2012
	PROVIDER OR SUPPLIE N HEALTH CARE		7465	r address, city, state, zip code MADISON AVE NAPOLIS, IN 46227	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=D	HIGHEST WELL Each resident m must provide the services to attair practicable phys psychosocial we the comprehens care. Based on obsercord review, identify a residentify	ust receive and the facility enecessary care and or maintain the highest ical, mental, and II-being, in accordance with ive assessment and plan of ervation, interview and the facility failed to dent's dental status layed dental attention Ients reviewed in a or dental status and ident #45) (Resident	F0309	F309 483.25 PROVIDE CARESERVICES FOR HIGHEST WELL BEING It is the practice Madison Health Care Center of provide the necessary care an services to attain or maintain highest practicable physical, mental, and psychosocial well-being, in accordance with comprehensive assessment a plan of care. I. Resident #136 has been assessed by the deprovider for replacement of the partial plate. Resident #45 has had a new oral assessment completed. The care plan and MDS were updated. II. An oral assessment was completed or residents to further identify an other residents with missing to or dentures. Care plans were updated accordingly. Oral assessments and care plans were updated accordingly. Oral assessments and care plans be reviewed and updated quarterly and with significant changes. III. The facility conducted an inservice for licensed nurses regarding the importance or completing an accurate oral assessment. A oral assessment tool was implemented to further aid in the service of the particular or the provider of the provider or the	e of to and the and th

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIII	I DDIG	00	COMPLE	ETED
		155780		LDING		08/31/2	2012
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
MARIOO	NILIEAL TIL CADE (CENTED			ADISON AVE		
MADISOI	N HEALTH CARE (SENTER		INDIAN	APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	CORRECTION (X	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the facility. At	this time, Resident			process. Licensed nurses we		
	#136 was observed to have a top educated on the use of this ne		:W				
		sing. She indicated it			assessment form. IV. The		
	was "unsightly	_			Director of Nursing or her		
	was ansignity	•			designee is completing quality		
	During on inter	riou with the Casial			improvement audits. A randor sample of 10% of residents wi		
	_	view with the Social			be reviewed to ensure that de		
		tor on 8/30/12 at 3:35			status has been assessed		
		ated she spoke with			accurately. Quality improvement	ent	
		and was told by			audits will be completed week		
	Resident #136	that she broke her			for 30 days; then every other		
	partial on 4/11/	/12. "She never told			week for 30 days; then monthl		
	•	ely on nursing staff to			thereafter. Results of all audits		
	_	e don't see them			are being discussed monthly		
		sing should point out			the quality assurance meeting		
		_			additional recommendations a	S	
	things like that	•			necessary.		
		as conducted with the					
	,	of Nursing) on 8/31/12					
	at 10:38 a.m.,	regarding the Social					
	Services Direc	tor's above statement					
	that "Nursing s	hould point out things					
	_	DON indicated, "There					
		ent, quarterly, that					
		sident have missing or					
	,	I'll go look and see					
		•					
	-	uarterly nursing					
	assessment sa	ays.					
	_	r interview with the					
	DON on 8/31/1	2 at 11:27 a.m., she					
	clarified that Re	esident #136 had a top					
	partial plate of	just the one tooth and					
		top and bottom teeth					
		al teeth. She clarified					
	that the top par	rtial plate had been in					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780		A. BUI	LDING	NSTRUCTION 00	(X3) DATE COMPL 08/31/	ETED	
		100100	B. WIN		DDDECC CITY CTATE ZID CODE	30/01/	
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
MADISO	N HEALTH CARE (CENTER			APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	COMPLETION
TAG				TAG	DEFICIENCT)		DATE
		Irawer the whole time					
		e nor staff were aware					
		The top partial plate that the framework was					
		nger fit Resident #136.					
		at the top tooth on the					
	•	act. She indicated, live a learning curve					
	,	er assessments in					
		ke with (name of nurse					
		training). Her bottom					
	•	wn. Her upper teeth					
		ial of just the one					
	-	Her partial has been in					
	_	whole time. She					
		wear it. It doesn't fit.					
		and the one side is					
		They don't fit. On					
		nily checked dental					
		request. The 8/23/12					
	•	t looks like she (nurse					
		l assessment) marked					
	•	marked lower and a					
		ning about natural or					
	·	vill review how to do					
		nts. (Name of MDS					
		oked in the drawer this					
	·	ound the partial in the					
	_	to find out if there's a					
	disconnect bet	ween sides of the					
	building. Until	this morning, we didn't					
	_	al has been in the					
	-	ole time, because she					
		r it. We'll definitely					
	pursue the den	tist." When informed					

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Event ID: 35SZ11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155780	A. BUILDING	00	COMPLETED 08/31/2012
		155760	B. WING		00/31/2012
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
MADISO	N HEALTH CARE	CENTER		IADISON AVE IAPOLIS, IN 46227	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	
PREFIX	· ·	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERIOR DEFICIENCY)	PRIATE
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		referred to her missing			
		htly", the DON			
		ybe that's why she's not			
		her room." She			
		s not even an option for			
		to wear her partial			
	•	e it didn't fit. She			
		nad no idea how long n't fit her. She stated,			
		I would have expected			
		ognize the missing			
	_	f she had been on this			
		vith, we would have			
	1	s to begin with. I don't			
	know if her pa	•			
	Kilow ii fiei pai	itial ever iit.			
	During anothe	r interview with the			
	I -	12 at 1:28 p.m., she			
		entist did come in, and			
		name of Resident			
	#136).	iame of resident			
	#100).				
	Review of the	8/31/12 dental note for			
		indicated, "Dropped			
		tial denture) frame work			
		fixed must be remade."			
	20.11, 00.11 00				
	2. The clinical	record for Resident #45			
		on 8/30/12 at 11:00			
		noses for Resident #45			
	_	vere not limited to:			
	hypertension,				
	••	depression, and			

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155780	B. WIN	G		08/31/	2012
NAME OF I	PROVIDER OR SUPPLIER	}		STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ADISON AVE		
MADISO	N HEALTH CARE (CENTER		INDIAN	APOLIS, IN 46227		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENC!)		DATE I
	anemia.						
	dated 9/1/11, of #45 had missing	Nursing Assessment, only indicated Resident ng teeth, no natural or vere indicated in the					
	teeth, no missi were indicated	lated 10/17/11, dent #45 had natural ng or broken teeth in the assessment .					
	A Quarterly Nursing Assessment, dated 7/11/12, indicated Resident #45 had natural, missing, and broken teeth.						
	dated 7/12/12	a Set) assessments, and 8/24/12, indicated did not have any broken					
	(Director of Nu facility had just survey, that the dental assessr When the dent assessment is the facility had routine dental s	1:30 p.m., the DoN rsing) indicated the t identified, during the ere were issues with ments and services. cal services and sues were identified, decided to initiate services, instead of dents to request dental					

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PRINTED: 09/26/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780 A. BUILDING DO DO DO DO DO DO DO D	X5) LETION TE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7465 MADISON AVE	LETION
NAME OF PROVIDER OR SUPPLIER 7465 MADISON AVE	LETION
	LETION
	LETION
PROVIDER'S PLAN OF CORRECTION	
CROSS-REFERENCED TO THE APPROPRIATE	IE
THE REGULATOR DE DEPART THE INFORMATION IN THE PROPERTY OF THE	
services, which was the facility's past	
practice. She also indicated the	
facility was going to have someone come in and educate staff on dental	
assessments, since the staff had	
inconsistent dental assessments.	
The DoN also indicated that if a	
Quarterly Nursing Assessment	
indicated there were missing or	
broken teeth in a resident's mouth,	
that issue should've been brought up	
to the appropriate staff member so a	
dental appointment can be made.	
The DoN indicated the results from	
the Quarterly Nursing Assessment,	
for Resident #45, was not brought to	
the attention of the appropriate staff	
for follow up.	
In an interview with MDS Coordinator	
#2 on 8/31/12 at 2:00 p.m., she	
indicated she did an oral assessment	
for the 8/24/12 MDS, for Resident	
#45, and there were no broken teeth.	
MDS Coordinator #2 indicated the	
7/11/12 Quarterly Nursing	
Assessment was not done	
appropriately. She also indicated that	
she uses the Quarterly Nursing	
Assessments to code the MDS, but	
was just instructed by the DoN	
(Director of Nursing) that day to not	
use the Quarterly Nursing	
Assessment when coding the MDS	
until further notice.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155780			JLTIPLE CO .DING G	NSTRUCTION 00	(X3) DATE : COMPL 08/31/	ETED
	OVIDER OR SUPPLIER HEALTH CARE CENTER		7465 M	.DDRESS, CITY, STATE, ZIP CODE ADISON AVE APOLIS, IN 46227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION AND ADMINISTRATION AND ADMINISTRA		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
ii c a #	At 2:10 p.m., on 8/31/12, the DoN ndicated Resident #45 had not had dental services since she was admitted to the facility and Resident #45 will be on the top of list when the dentist comes in. 3.1-37(a)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155780	B. WING			08/31/	2012
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ADISON AVE		
MADISON	N HEALTH CARE C	CENTER			APOLIS, IN 46227		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323 SS=D		ENT RVISION/DEVICES ensure that the resident					
	•	ains as free of accident					
		sible; and each resident					
	•	e supervision and					
	assistance device	es to prevent accidents.					
			F03	23	F323 483.25(h) ACCIDENTS	lt	09/30/2012
	Based on obse	rvation, interview, and			is the practice of Madison Hea		
	record review,	the facility failed to			Care Center to ensure that the		
	ensure potentia	-			resident's environment remain	-	
	-	locked up with the			as free from accident hazards is possible; and each resident		
		ect 1 of 17 residents			receives adequate supervision		
	· ·	ne beauty shop, during			and assistance devices to prev		
	_	rvation (Resident #69).			accidents. I. The beauty shop		
	a random obco	rvation (reolaone noo).			was secured immediately during		
	Findings includ	e:			survey. II. All residents have t potential to be affected. This i being addressed by the syster	S	
	During the initia	al tour of the facility, on			described below. III. Facility		
	_	p.m., the door to the			personnel have been re-educa	ated	
		as unlocked and open.			regarding the importance of	مام	
		n in the beauty shop.			securing all hazardous chemic including keeping the chemica		
	_	staff in the vicinity of			in the beauty shop locked whe		
		p. The beauty shop			unattended. This re-education		
	_	nlocked and open at			also included the beautician.		
		/27/12, with no staff in			is being monitored through our		
	-	ne beauty shop. A			quality improvement program. IV.The Administrator or her		
	•	locked and L'Oreal			designee is completing quality		
		rence Complete Color			improvements audits of the		
	· -	•			beauty shop to ensure chemic	als	
	,	ye), Revion Colorsilk			are secured when unattended		
		r dye), Clariol Natural			This will be monitored at rando	om	
	•	lye), Waving Lotion			times throughout the day on a		
	•	ution), and hydrogen			weekly basis for 30 days; then every other week for 30 days;		
	•	within reach and			then monthly thereafter. Resi	ults	
	accessible.				of all audits are being discusse		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE S COMPL		
		155780	A. BUII B. WIN			08/31/	
NAME OF P	PROVIDER OR SUPPLIER		D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
					ADISON AVE		
	N HEALTH CARE C				APOLIS, IN 46227		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	DATE
PREFIX TAG	In a interview v at 6:50 p.m., sh knew they (the for the beauty shat the beauty locked. At 7:55 p.m., o (Director of Nu the beauty sho locked, if all the products were indicated that if products inside beauty shop do closed and locked. The following N Sheet (MSDS) DoN on 8/28/12 MSDS for L'Orand Permanen 12/18/03, indicharmful, if swal absorbed throufor Revlon Colo Developer, dat Creme Color, or	with RN #1 on 8/27/12 ne indicated that she facility) was in trouble shop and she agreed shop should've been n 8/27/12, the DoN rsing) indicated that p door wasn't always e cabinets with locked up. She also f the cabinets with e weren't locked, the por should've been wed. Material Safety Data were provided by the 2 at 10:15 a.m. The eal Semi-Permanent t Hair Dyes, dated ated the solution was lowed, inhaled, or egh skin. The MSDS		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ce	DATE
	cause eye/skin Lotion MSDS,	damage. The Waving dated 2/20/03,					
	The MSDS for	s very toxic, if ingested. hydrogen peroxide, indicated it was					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED	
155780		B. WING 08/31/2012				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MADISON HEALTH CARE CENTER			7465 MADISON AVE INDIANAPOLIS, IN 46227			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	ACTION SHOULD BE COMPLETION TO THE APPROPRIATE	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY) DATE		
	hazardous in case of contact with eyes, skin, ingestion, or inhaled.					
	Mental Status) residents resid hall was provid 8/28/12 at 10:7 indicated that I BIMS of 3 (ind cognitive impa independently					
	10:20 a.m., mareplacing the boone that automon its own. Shocks. The Donurses were s	ated on 8/28/12 at aintenance staff was beauty shop door with natically locks and shut he also indicated is replacing the cabinet N indicated the Night upposed to discourage oing down the beauty at night.				

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